ALTERNATIVE PART D BENEFIT DESIGNS AND OPTIONS FOR ENHANCING MEDICARE DRUG COVERAGE

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA established the Part D prescription drug benefit for Medicare beneficiaries. The foundation of Part D is the standard benefit design described below. However, the MMA provides potential plan sponsors with significant flexibility in the benefit design. In addition, beneficiaries selecting standard coverage will face significantly reduced or in some case no cost-sharing because of the low-income subsidy program and State Pharmacy Assistance Programs. The following paper briefly outlines the options for alternative benefit designs and other ways to reduce cost sharing.

The Standard Part D Benefit

Since beneficiary premiums and government subsidies for Part D plans will be determined based on a bidding process, the law establishes a benefit standard that would both serve as a minimum benefit and allow for comparisons across plans offered by various sponsors. Although drug plan sponsors may offer alternatives to the standard benefit design, any variant offered must meet certain actuarial tests. These tests vary for the different alternatives. In general, they assure either that average cost-sharing under the alternative is comparable to that under defined standard coverage or that the plan provides the same or greater value. The standard benefit structure includes:

- A deductible of $250;
- Coinsurance of 25 percent (or actuarially equivalent co-pays) up to an initial coverage limit of $2,250; and
- Protection against high out-of-pocket prescription drug costs, with co-pays of $2 for generics and preferred drugs that are multiple source drugs and $5 for all other drugs or coinsurance of 5 percent of the price once an enrollee's true out-of-pocket spending reaches a limit of $3,600.

Alternative Part D Basic Benefit Designs

Actuarially equivalent cost sharing

Part D plans have the option of offering defined standard coverage with different, actuarially equivalent cost sharing. For example, under the defined standard benefit beneficiaries would pay coinsurance of 25 percent for all drugs. An actuarially equivalent design might have tiered co-payments of a low dollar amount for a generic drug and higher amounts for preferred brand-name drugs and for non-preferred brand-name drugs. All other elements of the benefit design such as deductible and the initial coverage limit would be the same as for the standard Part D benefit. The same total number of prescriptions would be filled under both designs but the number of generic, preferred brand-name, and non-preferred brand-name drugs would be different. Differences in utilization for each tier would allow plan sponsors to obtain volume discounts and would lead to differences in cost per prescription for the sponsor. While for a

specific prescription an enrollee might pay more or less than 25 percent of the drug's cost, on average all enrollees would pay 25 percent of the total cost to the plan sponsor for the drugs they receive. Based upon current industry standards, we anticipate that many plans will choose to offer a benefit with tiered co-payments between the deductible and the initial coverage limit. It is also common for a benefit to have differential co-payments for prescriptions filled by mail order (lower) versus community pharmacies (higher).

Basic alternative coverage
Subject to certain actuarial tests, plan sponsors have considerable leeway to provide alternative coverage. While under actuarially equivalent standard coverage, the deductible and initial coverage limit is unchanged, under alternative coverage these benefit design features can be modified by reducing the deductible or other cost-sharing under the defined standard design. Under basic alternative coverage, this is done with a package that has the same actuarial value as defined standard coverage. (In enhanced alternative coverage, discussed below, the value of the plan is greater than that of defined standard.)

Reinsurance payment demonstration
The MMA Conference Committee noted, "the conditions under which the government provides reinsurance subsidies may create significant disincentives for private sector plans to provide supplemental prescription drug coverage." To address this concern, the conference report suggested use of the Secretary's current Medicare demonstration authority to allow plans the maximum flexibility to design alternative prescription drug coverage. CMS expects to conduct a reinsurance demonstration that represents an alternative payment approach. The demonstration would have to be budget neutral and will include the issuance of guidance beyond that given in the final Part D rule. The payment demonstration is expected to increase the number of offerings of supplemental benefits through enhanced alternative coverage.

Adding supplemental benefits to Part D basic coverage

Options for enhancing drug coverage
As illustrated below, the standard Part D benefit has a period of 100% coinsurance between the initial coverage limit of $2,250 and the dollar level at which catastrophic coverage begins (attachment point). The attachment point for the standard benefit is at the beneficiary true out-of-pocket threshold of $3,600 or $5,100 in total drug expenditures for beneficiaries without other prescription drug coverage.

There are a number of options for reducing cost-sharing in the period of 100% coinsurance. Plan sponsors may offer enhanced alternative coverage which includes supplemental benefits. Alternatively, State Pharmaceutical Assistance Programs (SPAPs) or former employers may offer coverage that coordinates with standard Part D coverage and thus reduces beneficiary cost-sharing. Finally, cost-sharing under defined standard coverage is reduced or eliminated for enrollees who qualify for the low-income subsidy program. Different kinds of additional coverage have different impacts on the level of total drug expenditures associated with the out-of-pocket threshold because of the true out-of-pocket (TrOOP) requirements under the law and they may impact beneficiary premium.

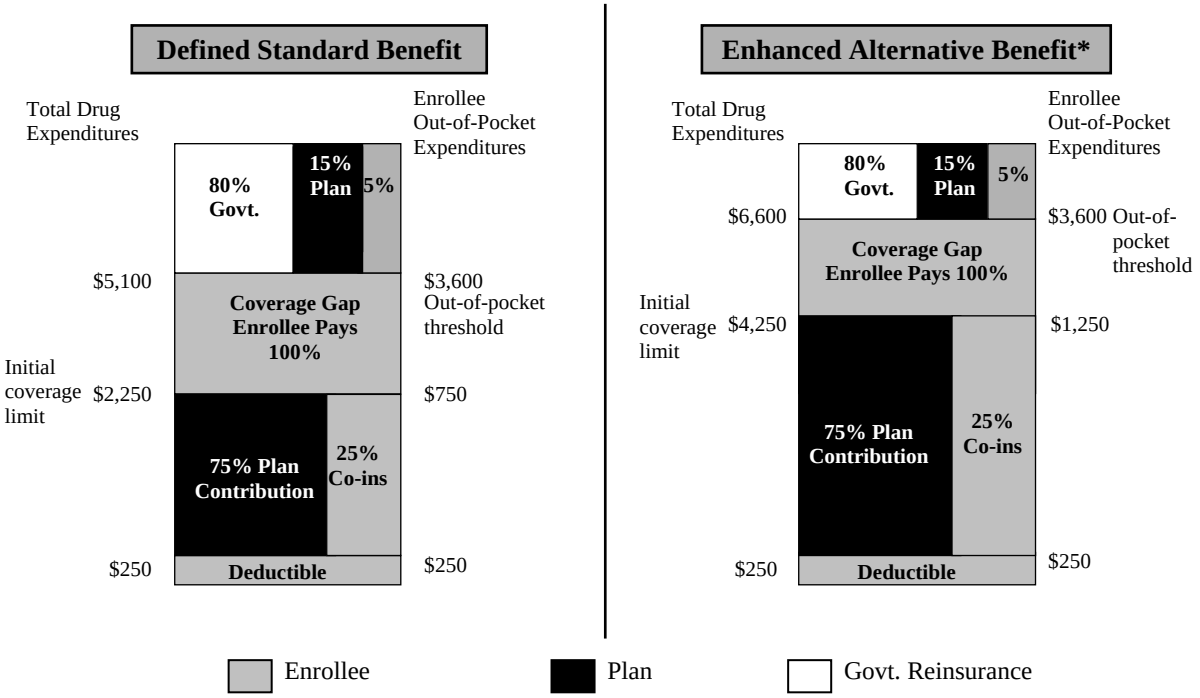
Beneficiary costs for Part D drugs are only considered to be true out-of-pocket (TrOOP) costs under two conditions. First, they must be incurred against the annual deductible (if any) or applicable cost-sharing under the plan up to the out-of-pocket threshold. Second, these costs must be paid by the Part D enrollee or by another person (including a charity) on behalf of that individual or by a qualified SPAP. Thus, if cost-sharing is paid by family members, charities, and qualified SPAPs, these costs still count towards the out-of-pocket threshold. If cost-sharing is paid by a group health plan, other insurance, government-funded health program or similar third party payment arrangements, it does not count toward the out-of-pocket threshold. However, even in these cases the beneficiary receives the full value of the "up front" drug coverage, with an actuarial value of over $900. If a beneficiary purchases enhanced coverage, the reduction in out-of-pocket payments moves the initiation point for catastrophic coverage to a higher level of total drug spending.

Enhanced alternative coverage

Enhanced alternative coverage is alternative coverage with an actuarial value greater than defined standard coverage. For example, an enhanced alternative benefit could increase the initial coverage limit by $2,000 over the standard benefit. The beneficiary would still be responsible for the 25% co-insurance for the amount between the $250 deductible and the $4,250 initial coverage limit for this plan design. Since coinsurance under the plan is reduced relative to the standard benefit, the attachment point for catastrophic coverage increases to $6,600 in total drug expenditures.

The beneficiary is responsible for the additional cost of the expanded coverage under enhanced alternative coverage that exceeds defined standard coverage. However, Medicare Advantage Prescription Drug Plans (MA-PDs) with A/B rebate dollars may buy down part or all of the additional premium. Moreover, employers and other payers can use their savings from Medicare's "up front" benefit to help cover the costs of the additional benefits. And beneficiaries can use their savings from the subsidized drug coverage or from no longer needing individual Medigap drug plans (if they had previously been enrolled) to pay for additional drug coverage.

Defined Standard Benefit & Example of Enhanced Alternative Benefit



* The beneficiary is responsible for the additional cost of the expanded coverage under enhanced alternative coverage. However, MA-PDs with A/B rebate dollars may buy down part or all of the additional premiums.

Low-income subsidy

The MMA establishes a substantial additional subsidy for low-income beneficiaries – about 30 percent of all Medicare beneficiaries. The low-income cost sharing subsidy reduces cost sharing throughout the benefit design for millions of beneficiaries who satisfy certain income and asset levels. Such beneficiaries face consistently reduced cost-sharing and a premium that is eliminated or substantially reduced.

Wrap-around coverage

Entities providing other prescription drug coverage (e.g., private health plans including employer retiree coverage, Veterans Health Administration, Indian Health Service, Federally qualified health centers, rural health centers, etc.) could reduce cost-sharing under the standard benefit by providing what is commonly referred to as wrap-around coverage that supplements the benefits available under Part D. As noted above, such additional coverage could be added to the Part D coverage between $250 and $2250 (with an actuarial value of over $900) and would push out the point at which Medicare's catastrophic coverage would begin.